**Purpose and instructions:** This checklist is to be completed by the sending site and shared with the receiving site, in order to ensure safe preparation of each patient/client/resident for evacuation or repatriation. Please **create three (3) copies**: one stays with the sending site, one goes into the patient/client/resident’s medical chart, and one is for the transport lead/escort to be given to receiving site.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Administrative information** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Patient Name** | | | | |  | | | | | | | | | | | | | | **Personal Health Number (PHN)** | | | | | | | | | | |  | | | | |
| **Name of emergency contact or next of kin** | | | | |  | | | | | | | | | | | | | | **Phone # of emergency contact or next of kin** | | | | | | | | | | |  | | | | |
| **Prepared by** | | | | |  | | | | | | | | | | | | | | **Date prepared** | | | | | | | | | | |  | | | | |
| **Relocation Information  Evacuation  Repatriation** | | | | | | | | | | | | | | | | | | | **Date of relocation** | | | | | | | | | | |  | | | | |
| **Sending site** | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Sending/primary physician**  Name & phone | | |  | | | | | | | | | | | | | | | | **Physician orders**  Attached/in medical chart | | | | | | | | | | | Yes | | | | No  N/A |
| **Receiving site** | | |  | | | | | | | | | | | | | | | | **Alternate destination**  If other than receiving site | | | | | | | | | | |  | | | | |
| **Arrival to receiving site**  Date & time | | |  | | | | | | | | | | | | | | | | **Received by**  Name & designation | | | | | | | | | | |  | | | | |
| **Emergency contact or**  **next of kin** | | | Notified of departure | | | | | | | | | | Yes  No | | | | | | **Date & time** | | | | | | | | | | |  | | | | |
| Notified of arrival | | | | | | | | | | Yes  No | | | | | | **Date & time** | | | | | | | | | | |  | | | | |
| **Handover Information** (medical, behavioural, clinical) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Acuity** | Is patient/client/resident **clinically stable** for transfer? | | | | | | | | | | | | | | | | | | | | | | | | | | ☐ Yes ☐ No | | | | | | | |
| **Medical diagnosis** | None | | | | HTN | | | | | | | Seizures | | | | | | | | | | | | | | | Stroke/TIA | | | | | | | |
| Diabetes | | | | | | | Mental Health: \_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
| **Cognitive**  **impairments** | None | | | | Yes, specify: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Safety**  **considerations** | None | | | | Aggression risk | | | | | | | | | | | Fall risk | | | | | | | | | | | | | | | Wandering (elopement) | | | |
| **Allergies** | None | | | | **Medications** | | | | | |  | | | | | | | | | | | | | | **Food** | | | | | | |  | | |
| *List on Allergy Alert wristband if available* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Activities of daily living** | I = Independent  A = Needs some assistance  D = Dependent | | | | | | | | | | **Bathing** | | | | | |  | | | | | | | | **Toileting** | | | | | | | | |  |
| **Dressing** | | | | | |  | | | | | | | | **Eating** | | | | | | | | |  |
| **Continence** | **Bladder** | | | Yes | | | No | | | | **Bowel** | | | | | | Yes | | | | No | | | | | | | | | | | | | |
| **Impairments** | None | | | | Hard of hearing | | | | | | | Deaf | | | | | | | | | | | Blind | | | | Visually impaired | | | | | | | |
| **Pre-trip considerations** | None | | | | Gravol | | | | | | | Ativan | | | | | | | | | | | | | | | Other PRN meds | | | | | | | |
| **Language** | Spoken language interpreter required? | | | | | | | | | | | | | | | | Yes | | | | | | No | | | | If yes, what language? \_\_\_\_\_\_\_\_\_\_ | | | | | | | |
| **Cultural considerations** | Identifies as Indigenous? | | | | | | | | | | Yes | | | No | | | | | | Other cultural considerations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | |
| **Infection control** | Droplet | | | | | | | Contact | | | | | | | | | | | Airborne | | | | | Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
| **Other special considerations** |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Transfer Considerations** (to be completed when preparing for relocation) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Medical directives** | | Medical directives (e.g. code status) signed and with the patient/client/resident | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Medical or non-medical escort needs** | | Is medical or non-medical supervision required for transportation? | | | | | | | | | | | | | | | | | | | | | | | | | | Yes | | | | | No | |
| If yes, indicate type and number required: | | | | | | | | | | | | | | | | | | Care Aide: \_\_\_\_\_\_ | | | | | | | | | RN: \_\_\_\_\_\_ | | | | | |
| LPN: \_\_\_\_\_\_ | | | | | | | | | Other: \_\_\_\_\_\_ | | | | | |
| **Spouse or other companions** | | Is there anyone who will accompany the patient/resident/client from the same facility? | | | | | | | | | | | | | Yes (select below) | | | | | | | | | | | No | | | | | | | | |
| Spouse, name: | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| Companion, name: | | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| Support/companion animal type: | | | | | | | | | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Mobility assessment** | | **Ambulatory** – not dependent on any mobility aids  **Ambulatory with assistance** – dependent on a mobility aid and/or transfer assistance  Mobility aid:  Cane Walker  Wheelchair  Scooter  Transfer assistance:  1-person assist 2-person assist  Lift, type: \_\_\_\_\_\_\_\_\_\_  **Wheelchair bound** – dependent on wheelchair  powered  unpowered  **Stretcher** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Mobility devices** | | List the mobility devices that will accompany patient/client/resident to receiving facility: | | | | | | | | | | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | |
| **Medication** | | Medication Administration Record (MAR)  **Send medications for at least 72 hours** Send any and all medications available for patient for transition period  **Special medications** E.g. IV therapy, chemotherapy, diabetic medications, etc.  Controlled substances (e.g. opioids) in transit recorded and monitored | | | | | | | | | | | | | | | | | | **Controlled substances in transit** (e.g. opioids) | | | | | | | | | | | | | | |
| Amount/dose sent: | | | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Transported by name: | | | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Signature: | | | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Controlled substances received** (e.g. opioids) | | | | | | | | | | | | | | |
| Amount/dose received: | | | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Received by name: | | | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Signature: | | | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Special transport considerations** | | Ventilator | | | | Suction | | | | | | CPAP | | | | | | | | Dialysis supplies, date of next treatment: \_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | |
| Oxygen required, L/min: \_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | IV pumps, fluids, supplies ☐ Ostomy supplies | | | | | | | | | | | | | | |
| ☐ Specialty mattress | | | | | | | | | | | | | | | | | | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | |
| **Personal items** | | Luggage - 1 piece | | | | | | | Hearing aids | | | | | | | | | Eye glasses | | | | | | | | Dentures  Other: | | | | | | | | |
| **\*Belongings must remain with patient/client/resident at all times\***  Note: if no luggage is available, place all personal items into 1 labelled pillow case | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Sustenance provisions** | | Bagged lunch/snacks | | | | | | | | Bottled water/juice | | | | | | | | | | | | | | | | | | | | | | | | |
| **Identification and labelling of property** | | Patient/resident/client has a wristband that indicates:   * Name * Date of birth * Sending facility * Receiving facility | | | | | | | | | | | | | | | | | | | | Property has been labelled with an adhesive label or wristband that indicates:   * Name * Date of birth * Sending facility * Receiving facility * Item \_\_\_ of total # \_\_\_\_ | | | | | | | | | | | | |
| **Other specific considerations** | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |